STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: May 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015329

[redacted]

Dear [redacted],

On April 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 31, 2017 plan enrollment notice and requested to be reimbursed for health insurance premiums.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 12, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000015329

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you and your spouse were enrolled in a qualified health plan (QHP), with a plan enrollment start date of March 1, 2017?
>
> Can NYSOH's Appeals Unit consider your request for reimbursement of your health insurance premiums for a health plan outside of NYSOH?

Procedural History

On December 14, 2016 and December 15, 2016, you submitted applications for financial assistance through NYSOH.

Also on December 15, 2016, you uploaded additional documentation to your NYSOH account.

On December 15, 2016 and December 16, 2016, NYSOH issued eligibility determination notices stating that you and your spouse were eligible to purchase a QHP at full cost through NYSOH, effective as of January 1, 2017. The notice stated in part that you and your spouse were not eligible for a tax credit and income-based cost-sharing reductions because they were missing information about your taxes.

On January 30, 2017, you resubmitted an application for financial assistance through NYSOH. NYSOH rendered a preliminary eligibility determination that you

and your souse were eligible for up to $718.00 monthly of advance premium tax credit (APTC) and cost-sharing reductions (CSR).

Also on January 30, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal of the March 1, 2017 plan enrollment start date of your QHP.

On January 31, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for up to $718.00 monthly of APTC and CSR, effective as of March 1, 2017.

Also on January 31, 2017, NYSOH issued a plan enrollment notice confirming that you and your spouse were enrolled in a QHP, with an enrollment start date of March 1, 2017.

On April 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was closed at the end of the hearing.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account, a completed financial assistance application was submitted for you and your spouse on December 14, 2016.

2) On December 15, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to purchase a qualified health plan at full cost through NYSOH, and not eligible for financial assistance because NYSOH was missing information about your taxes (*see* Document [redacted].

3) On December 15, 2016, your 2015 Form 1040 U.S. Individual Income Tax Return and 2015 New York State Resident Income Tax Return were uploaded to your account.

4) You testified that you contacted NYSOH on December 26, 2016, and were told by a representative that the documentation had not been reviewed.

5) You testified that you and your spouse enrolled in a [redacted] health plan, outside of NYSOH, for the months of January and February 2017.

6) You testified that you are seeking to be reimbursed for the monthly health insurance premiums that you paid to [redacted] for coverage in January and February 2017.

7) According to your NYSOH account, you and your spouse were enrolled in a [redacted], through NYSOH, on January 30, 2017, with an enrollment start date of March 1, 2017.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Enrollment in a Qualified Health Plan

The effective date of coverage by a qualified health plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i)). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Appealable Issues

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were enrolled in a QHP, with a plan enrollment start date of March 1, 2017.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is

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selected after the fifteenth day of a month goes into effect on the first day of the second following month.

Since you selected your QHP on January 30, 2017, it must take effect on the first day of the second following month after January 2017; that is, on March 1, 2017.

Therefore, the January 31, 2017 plan enrollment notice properly stated that you and your spouse's QHP would begin on March 1, 2017, and is AFFIRMED.

The second issue under review is whether NYSOH's Appeals Unit can consider your appeal to seek reimbursement of your health insurance premiums for a health plan outside of NYSOH.

You testified that you and your spouse enrolled in a health insurance plan outside of NYSOH for the months of January 2017 and February 2017. Furthermore, you are seeking to be reimbursed for the premiums that you paid for those months.

NYSOH Appeals Unit only has the authority to review issues related to the following: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, (4) a failure to provide timely notice of an eligibility determination and (5) a denial of a special enrollment period.

The Appeals Unit does not have the authority to review whether an individual should be reimbursed for premiums paid to a health plan outside of NYSOH. As such, the merits as to whether you are entitled to be reimbursed for those payments cannot be reached. Therefore, your request for reimbursement for amounts paid to [redacted] for your and your spouse's coverage during the months of January and February 2017 is DISMISSED as a non-appealable issue.

Decision

The January 31, 2017 plan enrollment notice is AFFIRMED.

Your request for reimbursement for amounts paid to [redacted] for your and your spouse's coverage during the months of January 2017 and February 2017 is DISMISSED as a non-appealable issue.

Effective Date of this Decision: May 12, 2017

How this Decision Affects Your Eligibility

This decision does not change your or your spouse's eligibility.

Your enrollment in your QHP properly began as of March 1, 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 31, 2017 plan enrollment notice is AFFIRMED.

Your request for reimbursement for amounts paid to for your and your spouse’s coverage during the months of January 2017 and February 2017 is DISMISSED as a non-appealable issue.

This decision does not change your or your spouse’s eligibility.

Your enrollment in your QHP properly began as of March 1, 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

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Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية(Arabic)

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هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

[illegible] (Bengali)

[illegible] 1-855-355-5777 [illegible]

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu)اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

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אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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